

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4501	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/08/2013
NAME OF PROVIDER OR SUPPLIER JEFFERSON CITY HEALTH AND REHAB CENT			STREET ADDRESS, CITY, STATE, ZIP CODE 283 W BROADWAY BLVD JEFFERSON CITY, TN 37760		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 902	<p>1200-8-6-.09(2) Life Safety</p> <p>(2) The nursing home shall provide fire protection by the elimination of fire hazards, by the installation of necessary fire fighting equipment and by the adoption of a written fire control plan. Fire drills shall be held at least quarterly for each work shift for nursing home personnel in each separate patient-occupied nursing home building. There shall be a written report documenting the evaluation of each drill and the action recommended or taken for any deficiencies found. Records which document and evaluate these drills must be maintained for at least three (3) years. All fires which result in a response by the local fire department shall be reported to the department within seven (7) days. The report shall contain sufficient information to ascertain the nature and location of the fire, its probable cause and any injuries incurred by any person or persons as a result of the fire. Initial reports by the facility may omit the name(s) of resident(s) and parties involved, however, should the department find the identities of such persons to be necessary to an investigation, the facility shall provide such information.</p> <p>Authority: T.C.A. §§4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-206, and 68-11-209.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire hazards were eliminated. The findings include: Observation with the Maintenance Supervisor, in the facility on December 8, 2013 at 1:30 a.m. confirmed room 416 had an excessive fuel load consisting of paperback books and combustibles along the wall by the window adjacent to the</p>	N 902	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of Federal and State law require it.</i></p> <p>N902</p> <p>Resident and family in room 416 met with Social Services Department and stored items removed for fire safety purposes by 1/03/14.</p> <p>Other rooms will be checked by 12/20/13 for excess fuel load of storage in the rooms, and any found removed by 1/10/14. Monthly room checks will continue to ensure excess storage by residents is not kept in the rooms.</p> <p>Excessive storage of items in rooms by residents will be reviewed monthly in the Facility QAA.</p>	1/23/14	

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6800

RFN521

If continuation sheet 1 of 2

PRINTED: 12/11/2013
FORM APPROVED

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N 902	Continued From page 1 through wall air conditioning unit. This finding was verified by the Maintenance Supervisor and acknowledged by the Administrator during the exit conference on December 8, 2013.	N 902		

Division of Health Care Facilities
STATE FORM

5990

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If continuation sheet 2 of 2